PATIENT CONTACT & DEMOGRAPHICS

WELCOME At Adjustments Chiropractic, we like to keep things simple. Only necessary information is gathered and is strictly confidential. Please complete the forms below and if you have difficulty understanding any portion of this form, please ask for assistance.

CONTACT INFORMATION

Legal Name *(First, Middle, Last)* _____ Preferred Name: _____

Address _____ City _____ State _____ Zip _____

Home Number _____ Mobile Number _____ Work Number _____

Best number to call?* *(Circle)* Home Mobile Work Email** _____

Birth Date _____/_____/_____ Sex *(Circle)* M / F / O Who referred you? _____

Emergency Contact _____ Contact Phone _____

(*Minors Only*) Parent Name _____ Contact Phone _____

□ Please check if you give us permission to text you about appointment reminders or important notifications about your treatment.

PAYMENT & TRANSPARENCY OF FEES

I understand that I am responsible to pay for services rendered in full at the time of service. Payment may be in the form of cash, personal check, Visa, Mastercard, HSA Card, or FSA Card. I understand that Adjustments Chiropractic and Wellness and Dr. Aivalotis does not participate with my insurance plan and I am seeking care by my own choice as elective services. I recognize that all charges are posted in the office and are fully transparent. I understand that balance billing is not permitted. I understand that fees for services are non-refundable.

Fees as of the time of this notice are as follows:
Adjustments = $65
Consultations = $65
New Patient Visits = $130
Fees for other services are as posted.

RECORDS

Patient records will be stored via electronic media only as of 09-01-2022. All paper documents will be scanned and shredded in accordance with applicable laws. To ensure the highest level of privacy, documents of any type will only be provided directly to the patient. Absolutely no outside entity will receive a document from this office. This includes doctors, other care providers, attorneys, and places of employment. Only under the direction of an official court order will documents be released. Additionally, a private server is used to store data. This will lessen the chances of data breaches and ensure that privacy is maintained.

Patient Signature _____ **Date** _____/_____/_____

NEW PATIENT HEALTH HISTORY

Name: _____ Today's Date _____

INSTRUCTIONS Please FILL-IN or CIRCLE all responses. If you have questions, please ask a staff member for assistance.

IF YOU ARE HERE FOR WELLNESS OR MAINTENANCE AND HAVE NO SYMPTOMS, WRITE N/A AND SKIP TO SECTION #13

1. Chief Complaint (What problem(s) or condition(s) would you like us to examine?) _____

_____

2. Please explain how the injury started. Unknown No Injury Old Injury Slip or Fall Overexertion Repetitive Use Slept Wrong
   Other (Explain) _____

3. When did your symptoms start? _____ What were you doing? _____

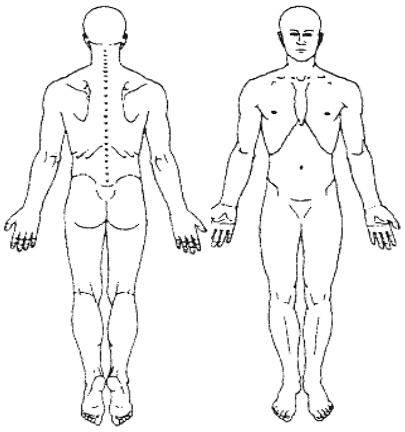
4. Have the symptoms ever occurred before? Yes No If Yes, when and how often? _____

5. How would you describe your current symptoms? Sharp/Shooting Pain Radiating Pain Localized Pain Diffuse Pain Dull Ache
   Numbness/Tingling Stiffness Weakness Burning Throbbing
   Other (Explain) _____

6. Rate your level of PAIN. (0=No Pain, 10=Severe Pain) 0---1---2---3---4---5---6---7---8---9---10

7. Rate how you pain interferes with Activity. (0=No Pain, 10=Severe Pain) 0---1---2---3---4---5---6---7---8---9---10

8. Please mark the area of your symptoms on the diagram to the right.



9. Is your condition? Worsening Improving Unchanging Constant Comes and Goes

10. When is your condition worse? Morning Afternoon Night With Activity

11. Do your symptoms seem to be better with? Nothing Stretching Cold Heat
    Rx Medications Massage Movement Walking Standing Sitting Rest
    OTC Medications Exercise Chiropractic Bending Activity
    .

12. Circle any of the following signs or symptoms that are associated with your current condition.

Joint Stiffness	Restricted Motion	Muscle Spasm	Redness	Deformity
Headaches	Loss of Coordination	Weakness	Cold Limb	Heat
Radiating Pain	Abnormal Sensation	Swelling	Nausea	Fatigue
Body Ache	Numbness /Tingling	Dizziness	Vomiting	

PAST HEALTH HISTORY

13. Please list any other doctors or providers that you have seen for your condition(s) and the treatment provided. _____

_____

14. Adult and Childhood Illnesses. (Please list any significant or current illnesses.) _____

_____

15. Surgeries. (Please list all surgical procedures that have had in the past and approximate date.) _____

_____

16. Injuries. (Please list any significant injuries, falls, trauma, accidents that you have had in the past.) _____

_____

Reviewed by: _____ D.C.

17. Non Drug Allergies. (Please list allergies and how you react to those substances.) _____

_____

FAMILY HISTORY

18. Please complete the chart below indicating as much information as you know about your family.

General Family	Alive	Deceased	Health Conditions		Alive	Deceased	Health Conditions
Father	☐	☐	_____	Son(s)	☐	☐	_____
Mother	☐	☐	_____	Daughter(s)	☐	☐	_____
Brother(s)	☐	☐	_____	Sister(s)	☐	☐	_____
Paternal Grandfather	☐	☐	_____	Maternal Grandfather	☐	☐	_____
Paternal Grandmother	☐	☐	_____	Maternal Grandmother	☐	☐	_____

SOCIAL HISTORY

19. Do you use any of the following regularly? (circle) Tobacco Alcohol Caffeine White Sugar Illegal Drugs Restricted Diet

20. Please list any medications or nutritional supplements that you are currently taking. _____

_____

21. Please rate the following. 0=Not Affected, 1=Annoying, 2=Painful but Not Limited, 3=Difficult to Perform, 4=Unable to Perform

Household Chores:	0---1---2---3---4	Sexual Activities:	0---1---2---3---4	Shaving:	0---1---2---3---4	Exercise:	0---1---2---3---4
Climbing Stairs:	0---1---2---3---4	Sleeping:	0---1---2---3---4	Dressing:	0---1---2---3---4	Work Tasks:	0---1---2---3---4
Looking Up:	0---1---2---3---4	Sitting:	0---1---2---3---4	Lifting:	0---1---2---3---4	Yard Work:	0---1---2---3---4
Looking Down:	0---1---2---3---4	Standing:	0---1---2---3---4	Driving:	0---1---2---3---4	Recreation:	0---1---2---3---4
Carrying Groceries:	0---1---2---3---4	Daily Pet Care:	0---1---2---3---4	Bending:	0---1---2---3---4	Gripping:	0---1---2---3---4
Change Positions:	0---1---2---3---4	Kneeling:	0---1---2---3---4	Walking:	0---1---2---3---4	Computer Use:	0---1---2---3---4

22. Please describe your type of work and daily work duties. _____

23. Is there anything that you would like to discuss that has not been covered here? _____

REVIEW OF SYSTEMS

24. Please circle any of the conditions below that you have had in the past 1 year or are currently experiencing.

Constitutional	Frequent Colds	**Gastrointestinal**	Painful Menses	**Skin**	Appetite Changes
Fever	Nasal Congestion	Apetite Loss	Urine Retention	Rash or Hives	Suicidal Thoughts
Chills	Nose bleeds	Difficulty Swallowing	Vaginal Bleeding	Nail Texture Change	Sleep Disturbance
Drowsiness	Post Nasal Drip	Heartburn	Vaginal Discharge	Skin Color Change	**Hematology/Lymph**
Fatigue	Sinus Pain/Infections	Nausea	Miscarriage(s)	Hair Growth	Anemia
Night Sweats	Hoarseness	Vomiting Blood	Difficult Pregnancy	Hair Loss	Blood Clotting Problems
Weight Gain	Sore Throats	Rectal Bleeding	**Male**	Excessive Sweating	Blood Transfusion(s)
Weight Loss	Bleeding Gums	Constipation	Burning Urination	Skin Lesions or Ulcers	Bruises easily
Eyes	Tooth Extraction	Diarrhea	Erectile Dysfunction	**Nervous System**	Lymph Node Swelling
Blurring	Altered Taste	Abdominal Pain	Frequent Urination	Seizures or Tremors	Lymph Node Tenderness
Double Vision	Abcess	Belching	Hesitancy or Dribbling	Dizziness	**GU**
Light Sensitivity	**Respiratory**	Black, Tarry Stools	Prostate Problems	Facial Weakness	Pain in the Side
Eye Pain	Shortness of Breath	Thin Stools	Urine Retention	Headaches	Pain in the Groin
Change in Vision	Wheezing	Hemorrhoids	**Endocrine**	Limb Weakness	Urinary Urgency
Eye Trauma	Cough	Indigestion	Goiter	Loss of Consciousness	Urinating at Night
Itching	Coughing up blood	Yellow Skin	Cold Intolerance	Loss of Memory	Blood in Urine
Tearing	Sputum Production	Excessive Gas	Heat Intolerance	Numbness	Urinary Hesitancy
Wears Glasses	**Cardiovacular**	**Female**	Diabetes	Slurred Speech	STD
Ears, Nose & Throat	Chest Pain	Birth Control Therapy	Excessive Appetite	Unsteadiness of Gait	Urinary Itching
Hearing Loss	Leg Swelling	Breast Lumps/Pain	Excessive Thirst	**Psychological**	Prior Kidney Stones
Ear Pain	Leg Pain/Aching	Burning Urination	Frequent Urination	Depression	
Ear Discharge	Heart Murmur	Cramps	Hair Loss	Mood Changes	
Ear Ringing	Heart Palpitations	Frequent Urination	Unusual Hair Growth	Confusion	
Dizziness	Ulcers	Hormone Therapy	Voice Changes	Anxiety/Nervousness	
Loss of Smell	Varicose Veins	Irregular Menstruation		Irritability	

Reviewed by: _____ D.C.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (HIPAA)

We are very concerned with protecting your privacy. While the law requires that you give us this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We will make a good faith attempt to disclose the least information possible and when possible, only release records directly to you, the patient.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy for our privacy notices.

I authorized Adjustments Chiropractic and Wellness to contact me with information related to my personal health needs and interests. The physician's office may use any phone number and email in my personal records to contact me. If contact is made by phone and I am unable to respond, a message may be left with my home answering machine, voice mail service or text messaging. I may be contacted about the following:

- Appointment reminders or schedule changes.
- Information related to my care
- Other health related information that may be of interest to me

To contact me, I authorize Adjustments Chiropractic and Wellness to use and disclose the following information:

- My Name, Address and Phone Numbers
- The Name of my Physician and the Clinic where I was treated

Patient Name: _____ Date of Birth: _____
(PLEASE PRINT)

Address of Patient: _____ Phone: _____
(STREET)

_____
(CITY, STATE, ZIP CODE)

Adjustments Chiropractic and Wellness fully supports the protection of health information. Only the physician and office staff will use this information to contact you. While we retain the standard rights of disclosure as provided under HIPAA , this authorization allows us to access only the above authorized information for contact purposes. Failure to sign this authorization will not affect you treatment, payment or eligibility for benefits in any way.

This authorization will remain valid for ten (10) years from the date of signature. You may revoke this authorization at any time or request to receive a copy of the protected health information to be used by writing to Adjustments Chiropractic and Wellness, 7900 Steubenville Pike, Suite 40, Imperial, PA 15126. In this case, every effort will be made to discontinue future communications.

_____ _____
Signature (PATIENT OR PERSON AUTHORIZED) Date

INFORMED CONSENT

IT IS REQUIRED THAT YOU READ & UNDERSTAND FULLY

Pennsylvania State Law requires health care providers to obtain your **INFORMED CONSENT** prior to examination and treatment. You have a right as a patient to be informed about your condition, the recommended chiropractic adjustments and other chiropractic procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. The purpose of this form is to inform you, not to alarm you. What you are being asked to sign is a confirmation that you have been informed of the following:

EXAMINATIONS & X-RAYS This office does not perform in-house x-rays. All radiological services are referred to an outside facility and results are reviewed by a board certified radiologist. This ensures that we receive the highest quality images with the lowest amount of risk.

CHIROPRACTIC ADJUSTMENT/ CHIROPRACTIC MANIPULATIVE THERAPY (CMT) The doctor will use his hands and/or a mechanical device upon your body in such a way as to move or manipulate your joints in various directions. This procedure may cause an audible "pop" or "click" to be heard coming from your joints, which is not cause for alarm. **There are some material risks involved in doing these procedures as follows:**

- **Pain:** Chiropractic Manipulation, Physical Modalities (such as Electrical Stimulation, Ultrasound, Cold Laser Therapy, Trigger Point Therapy, etc.), or other treatments may result in a temporary increase in soreness in the area receiving treatment.

- **Rib Fractures:** Fractures caused by chiropractic treatments are rare. They occur most frequently in patients with osteoporosis or weakened bones. Evidence of osteoporosis can be noted on your x-rays, and if detected, the most appropriate, gentle treatments are used, minimizing the possibility of fractures to the ribs.

- **Disc Injury:** Chiropractic treatment is appropriate for the treatment of many kinds of back problems, including some disc problems (1). Occasionally, chiropractic treatment may aggravate or cause a problem if the disc is in a severely weakened state. However, this occurs so rarely that statistics to quantify the probability are unavailable, but estimates place the risk of serious injury at *about 1 serious complication per 100 million low back manipulations* (2).

- **Vertebral Artery Dissection (VAD)/Stroke:** The overall incidence of vertebral artery dissection/stroke in the general population is about *2 per 1000 people* (3). Although chiropractic adjustment/manipulation has been implicated as a possible cause of stroke, this possibility is extremely rare. The best available data suggests that stroke secondary to chiropractic adjustment/manipulation may occur *1 per 100,000 patients* (4)-a rate well below the overall average risk in the general population. In comparison, the overall average risk of death from taking non-steroidal anti-inflammatory drugs (i.e. Aspirin, Ibuprofen, Naproxen Sodium, etc.) is *4 per 10,000 patients* (5). The risk of serious complications or death from spine surgeries of the neck is *11.25 per 1000 patients* (5). As you can see, the risk of stroke from chiropractic treatments is much lower than other common medical treatments. Even though the risk is small, we have implemented procedures and tests that will likely reduce the potential for stroke even more.

- <u>This list is of side-effects IS NOT EXHAUSTIVE and there could be other negative side-effects</u> of various treatments rendered in this office.

X Initial: _____

I understand the risks and possible negative side effects of Chiropractic Care and other therapeutic modalities and treatments at Adjustments Chiropractic and Wellness that are involved in my treatment, and I have had the chance to ask questions of the doctor and staff regarding these procedures and make an informed

decision in the treatment of my condition(s). I understand the risks associated with such treatments, but wish to be treated nevertheless for my condition(s). By initialing these sections and signing this statement I authorize Dr. Donald L. Aivalotis, II and any or all members of the Adjustments Chiropractic and Wellness Staff to treat me using the methods designed by Dr. Donald L. Aivalotis, II /other doctors working for Adjustments Chiropractic and Wellness. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. Failure to disclose vital health information or changes in health status to the doctor is at the fault of the patient, and Dr. Aivalotis is held harmless to adverse events resulting from such non-disclosure.

X Initial: _____

Chiropractic is a second largest system of health care delivery. As with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this office. We will always give you our best care, and if your results are not acceptable, we will refer you to another health care provider who we feel will assist your situation.

ACCEPTANCE AS A PATIENT I understand and agree that **Dr. Donald L. Aivalotis, II** has the right to refuse to accept me as a patient at any time before treatment begins. The taking of a history and the conducting of a physical examination are not considered treatment, but are part of the process of information gathering so that the doctor can determine whether to accept me as a patient.

X Initial: _____

I HAVE BEEN INFORMED OF THE MOST LIKELY COMPLICATIONS OF THE POSSIBLE UNDESIRABLE RESULTS OF CHIROPRACTIC EXAMINATION, TREATMENTS, AND OTHER MODALITIES IN THIS OFFICE AND I UNDERSTAND THEM FULLY.

I hereby authorize and direct *Dr. Aivalotis and his associates or assistants* to provide services as they deem reasonable and necessary.

I HEREBY STATE THAT I HAVE READ, OR HAVE HAD SOMEONE READ TO ME, THIS CONSENT FORM

X _____ _____

Patient Name (PLEASE PRINT) Date

X _____ _____

Guardian's or Authorized Person's Name (PLEASE PRINT) Date

X _____ _____

Patient or Guardian's Signature Date

_____ _____

Witness' Name (PLEASE PRINT) Date

_____ _____

Witness' Signature Date